



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 1/14/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

The item in dispute is the prospective medical necessity of anterior cervical discectomy and fusion (ACDF) at C5-C6.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of anterior cervical discectomy and fusion (ACDF) at C5-C6.

A copy of the ODG was provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Clinical notes indicate that has been noted to have persistent neck and right shoulder pain since xx/xxxx. Occasional numbness was also noted. Medications have included Lyrica, Zanaflex, Norco and NSAIDS. Treatment was also noted to have included physical therapy and injections. Exam findings on August 25, 2014 revealed a normal neurological exam, decreased and painful cervical motion and positive Spurling and L'hermitte signs. There is a positive disc herniation at C6-7 with disc space narrowing and osteophytes also seen at C5-6. An August 30, 2014 dated cervical MRI revealed findings of a C6-6 disc protrusion and spondylosis with right-sided cord impingement at C5-6. At C4-5, C5 nerve root impingement was noted bilaterally. Electrical study stated July 24,

2014 discussed the history of a right shoulder MRI from July 22, 2014 with evidence of a torn labrum along with tendinosis. The study was noted to reveal no electrical evidence of cervical radiculopathy. A psychosocial screening from October 9, 2014 revealed a lack of clearance. The diagnoses included HNP at C6-7 with spondylosis along with C5-6, severe.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The clinical analytical findings do not appear to correlate with the significantly abnormal cervical MRI scan at multiple levels. A psychosocial screening did not support surgical clearance at the time. There is significant right shoulder pathology on the MRI which may also be contributing to the symptoms. Therefore, the applicable referenced guidelines have not been met in full with regards to the single level cervical fusion.

ODG Neck Chapter

Criteria for Cervical Fusion – Recommended Indications:

- (1) Acute traumatic spinal injury (fracture or dislocation) resulting in cervical spinal instability.
- (2) Osteomyelitis (bone infection) resulting in vertebral body destruction.
- (3) Primary or metastatic bone tumor resulting in fracture instability or spinal cord compression.
- (4) Cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain OR profound weakness of the extremities.
- (5) Spondylotic myelopathy based on clinical signs and/or symptoms (Clumsiness of hands, urinary urgency, new-onset bowel or bladder incontinence, frequent falls, hyperreflexia, Hoffmann sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait abnormality or pathologic Babinski sign) and Diagnostic imaging (i.e., MRI or CT myelogram) demonstrating spinal cord compression.
- (6) Spondylotic radiculopathy or nontraumatic instability with All of the following criteria:
  - (a) Significant symptoms that correlate with physical exam findings AND radiologist-interpreted imaging reports.
  - (b) Persistent or progressive radicular pain or weakness secondary to nerve root compression or moderate to severe neck pain, despite 8 weeks conservative therapy with at least 2 of the following:
    - Active pain management with pharmacotherapy that addresses neuropathic pain and other pain sources (e.g., an NSAID, muscle relaxant or tricyclic antidepressant);
    - Medical management with oral steroids, facet or epidural injections;
    - Physical therapy, documented participation in a formal, active physical therapy program as directed by a physiatrist or physical therapist, may include a home exercise program and activity modification, as appropriate.
  - (c) Clinically significant function limitation, resulting in inability or significantly decreased ability to perform normal, daily activities of work or at-home duties.

(d) Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates cervical nerve root compression, or Diagnostic imaging by x-ray demonstrates Instability by flexion and extension x-rays; Sagittal plane translation >3mm; OR Sagittal plane translation >20% of vertebral body width; OR Relative sagittal plane angulation >11 degrees.

(e) Not recommend repeat surgery at the same level.

(f) Tobacco cessation: Because of the high risk of pseudoarthrosis, a smoker anticipating a spinal fusion should adhere to a tobacco-cessation program that results in abstinence from tobacco for at least six weeks prior to surgery.

(g) Number of levels: When requesting authorization for cervical fusion of multiple levels, each level is subject to the criteria above. Fewer levels are preferred to limit strain on the unfused segments. If there is multi-level degeneration, prefer limiting to no more than three levels. With one level, there is approximately a 80% chance of benefit, for a two-level fusion it drops to around 60%, and for a three-level fusion to around 50%. But not fusing additional levels meeting the criteria, risks having to do future operations.

(h) The decision on technique (e.g., autograft versus allograft, instrumentation) should be left to the surgeon.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)